Division of Health Care Financing HCF 10100A (Rev. 04/04)

WISCONSIN FAMILY MEDICAID, BADGERCARE, AND FAMILY PLANNING WAIVER INSTRUCTIONS FOR APPLICATION AND REVIEW

This application is to be used by families with children under age 19 and pregnant women who are applying for Wisconsin Medicaid or BadgerCare, and for single women between the ages of 15 and 44 who are applying for the Family Planning Waiver. This is not an application for food stamps, child care, or W-2. If you are interested in applying for these assistance programs you must contact your local county/tribal social or human services agency or your W-2 agency. These programs provide single people or families help with the cost of food, the cost of child care, or finding a job as part of W-2.

If you need help filling out this application or wish to answer the questions in person or over the telephone, contact your local county/tribal social or human services agency. For other questions regarding Wisconsin Medicaid, BadgerCare, Family Planning Waiver or Food Stamps, please call Recipient Services at 1-800-362-3002. Information is also available on the Department of Health and Family Services Web site at: http://www.dhfs.wisconsin.gov/medicaid/.

If you have a disability and need to access the instructions and application in an alternate format or need it translated to another language, please contact Recipient Services at 1-800-362-3002 (toll free). All translation services and translated information are free of charge.

HOW TO USE THIS FORM

- 1. Read these instructions and important information completely before completing the application.
- 2. Print clearly. Use blue or black ink.
- 3. Fill out the application completely. Answer all the questions. There may be a delay in Medicaid, BadgerCare or Family Planning Waiver benefits if the application is not complete. If your application is not complete, your county/tribal social or human service agency will contact you for more information.
- 4. Do not write in the shaded sections.
- 5. Enter information about all the people that live in your household. If you need more space, add a second sheet.
- 6. If you are pregnant, please include with your application a signed and dated note from your doctor or another health care professional which states that you are pregnant, identifies your expected due date and whether you are expecting multiple births.
- 7. You may authorize a representative to apply for you. Contact Recipient Services at 1-800-362-3002 to have a form sent to you or visit our web site at http://dhfs.wisconsin.gov/medicaid1/applications.htm. This form authorizes a representative to complete and sign the application for you. A legal guardian, conservator or power of attorney/durable power of attorney may apply for an individual without separate authorization by the individual.

CODE KEYS

The following are the codes that are used in section II of the application.

Marital Status

Enter the code in the space provided that best describes each household member's marital status.

A = Annulled D = Divorced

LS = Legally Separated

M = Married

N = Never Married

S = Single

W = Widowed

Race / Ethnic Background (This information is voluntary and will not be used to determine eligibility.)

A = Asian B = Black

H = Hispanic origin

I = American Indian/Alaskan Native
P = Native Hawaiian or Pacific Islander

S = Southeast Asian

W = White

IMPORTANT INFORMATION

The following is important information regarding Wisconsin Medicaid, BadgerCare and Family Planning Waiver eligibility.

Your application date is the date your application is received by your county/tribal social or human services agency. The application must include at least your name, address and signature. A decision regarding your eligibility for Medicaid, BadgerCare or Family Planning Waiver will be mailed to you within 30 days of the application date. Unsigned forms will not be processed and will be returned.

It is important to apply as soon as possible. Eligibility for benefits is based on your application date. If you are eligible, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in those months. If you want help paying for health care for any of the three months prior to your application date (backdating), make sure you checked the "Yes" box on the application where the backdating question is asked and complete the Request for Medicaid Backdating form (HCF 10100B) in this packet.

There is no backdating for BadgerCare or Family Planning Waiver. Eligibility for these programs can begin no earlier than the first of the month in which you apply.

- Your rights and responsibilities are provided in the Wisconsin Medicaid Program Eligibility and Benefits brochure (PHC 10025). If you do not have a brochure, you may obtain one at your local county/tribal social or human services department or by calling Recipient Services at 1-800-362-3002. If you have any questions about your rights and responsibilities contact your local county/tribal social or human services agency or Recipient Services at 1-800-362-3002.
- If you are found eligible for Medicaid, BadgerCare, or the Family Planning Waiver you will need to complete a review every 12 months to determine your continued eligibility.

PERSONAL INFORMATION

Under Wisconsin Statute section 49.45 (4), personally identifiable information is kept confidential and is only used for the administration of the Medicaid, BadgerCare and Family Planning Waiver programs.

SOCIAL SECURITY NUMBER

If someone in your household is not applying for Medicaid, BadgerCare or the Family Planning Waiver you do not need to provide SSN information for that person. Providing or applying for an SSN is voluntary; however any person who wants Wisconsin Medicaid, BadgerCare or Family Planning Waiver, but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

If you are applying only for emergency services because of your immigration status, you do not need to provide SSN information.

SSN information will be used for administration of the Medicaid, BadgerCare and Family Planning Waiver programs. Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration and the Department of Workforce Development. In addition, the Department will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

Your SSN will not be shared with the United States Citizenship and Immigration Services (USCIS).

REPORTING CHANGES

Report to the agency within 10 days:

- Any changes in income of any member of my household, AND
- Any other change in the information I have given on my application that is required to be reported on the Medicaid Change Report form.
- For the Family Planning Waiver program, only changes in residency need to be reported within 10 days.

Changes can be reported using the Medicaid Change Report Form (HCF 10137), which can be found in this application packet.

CITIZENSHIP

All persons living in your household and applying for aid must be citizens or nationals of the United States or are in a satisfactory immigration status. The immigration status of any person in your household who is applying for benefits will be verified with the United States Citizenship and Immigration Services (USCIS). Information from USCIS may affect your household's eligibility and amount of benefits. Immigration status will not be verified with USCIS for people in your household who are not applying for assistance.

CHILD SUPPORT COOPERATION

You must cooperate with the Child Support Agency to establish paternity, by helping to locate absent parents, legally naming the absent parent and/or enforcing child support orders if you are requesting Medicaid, BadgerCare or Family Planning Waiver in some situations, for a child with an absent parent. Failure to cooperate with the Child Support Agency without good cause may result in termination or a reduction in benefits for adults who are not pregnant.

OTHER MEDICAL COVERAGE

As a condition of Medicaid and BadgerCare eligibility, you must report to the agency any third party who may be liable to pay for medical care for yourself and your family. You must cooperate by giving information as requested. This also includes any insurance that may be available through an absent parent or an employer's group health insurance.

RECOVERY OF MEDICAID

Wisconsin state law provides for the recovery of certain Medicaid and BadgerCare benefits you receive in error. The law also provides for the recovery of certain Medicaid benefits you receive after you turn 55 years old and all Medicaid benefits you receive while you are a resident in a nursing home and while you are an inpatient in a hospital for 30 days or more. Under limited circumstances a lien may be placed on your home for benefits you receive while you are residing in a nursing home if you are unlikely to return home and your spouse (or minor/disabled son or daughter) does not live in the home.

RIGHTS AND RESPONSIBILITIES

Your signature on the application means that you understand and acknowledge that the county/tribal social or human services agency, W-2 agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid, BadgerCare and Family Planning Waiver programs authorized under Wisconsin law. Any persons, including financial institutions, credit reporting agencies, or educational institutions are authorized to release this information, unless access to the information is prohibited or restricted by law.

FAIR HEARING

You have the right to appeal any action taken concerning your Medicaid, BadgerCare, or Family Planning Waiver application or on going benefits that you do not agree with by requesting a Fair Hearing. You may request a Fair Hearing by writing to:

Wisconsin Department of Administration Division of Hearings and Appeals P.O. Box 7875 Madison, WI 53707-7875

or by calling: Telephone (608) 266-7709

The "Request for Fair Hearing" form can also be found on the Division of Hearings and Appeals web site at http://dha.state.wi.us/home/.

You may also contact the office where I applied and ask for assistance with filing a Fair Hearing request. I understand that I can refer to the *Wisconsin Medicaid Program* – *Eligibility and Benefits* brochure (PHC 10025) Pamphlet or my Notice of Decision for more information on the fair hearing process.

The Department of Health and Family Services (DHFS) is an equal opportunity employer and service provider. For civil rights questions, call (608) 266-3465 (voice) or (608) 266-2555 (TTY).

To file a complaint of discrimination contact either the:

Wisconsin Department of Health and Family Services (DHFS)
 Affirmative Action and Civil Rights Compliance Office
 1 W. Wilson, Room 555
 Madison, WI 53707-7850

Telephone: (608) 266-9372 (Voice); (608) 266-5555 (TTY)

Fax: (608) 267-2147

or

U.S. Department of Health and Human Services
 Office for Civil Rights – Region V
 233 N. Michigan Avenue
 Suite 240
 Chicago, IL 60601

Telephone: (312) 886-5077 (voice) or (312) 353-5693 (TTY)

CHECKLIST

☐ Is the application complete?

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If you are not a U.S. citizen, did you include a copy of both sides of your immigration status documents?
If you are pregnant, did you include a signed and dated note from a doctor or other health care professional saying that you are pregnant and stating the due date?
Did you read the Rights and Responsibilities Section?
Did you sign and date the application form?
Did you include the Authorized Representative Form if you are acting on behalf of an applicant?
Did you include the Request for Medicaid Backdating, if you are requesting that your coverage be backdated?
Did you keep the Instructions and Important Information (pages 1 through 4) and the Medicaid Change Report (HCF 10137), for future use?

Send the completed application to your local county/tribal social or human services department, W-2 agency or Medicaid outstation site. Addresses for county/tribal agencies can be found at: http://www.dhfs.wisconsin.gov/Medicaid1/contacts/recipient-contacts.htm or by contacting Recipient Services at 1-800-362-3002. Keep the Instructions and Important Information (pages 1 through 4) and the Medicaid Change Report (HCF 10137), for future use.

OTHER PROGRAM INFORMATION

If you are interested in services for veterans, call 1-800-947-8347 (WIS-VETS), or contact your county Veteran Service Officer.

For information about the Women, Infants, and Children (WIC) Nutrition Program, call 1-800-722-2295.

For information about services for women, children and families, contact the Wisconsin Maternal Child Health Hotline at 1-800-722-2295.

DEPARTMENT OF HEALTH AND FAMILY SERVICES

Division of Health Care Financing HCF 10100 (Rev. 04/04)

STATE OF WISCONSIN WI Statutes s.49.47

WISCONSIN FAMILY MEDICAID, BADGERCARE, AND FAMILY PLANNING WAIVER APPLICATION

Use blue or black ink. Do not write in the shaded areas. If more space is needed, use an additional sheet of paper. Write all dates in the MM/DD/YY format (Example 04/02/58).

SECTION I – CLIENT INFORMATION									
Do you need help paying for health care in any of the previous three months, for any member of your household?									
☐ Yes ☐ No If you checked "Yes", complete the Request for Medicaid Backdating form (HCF 10100B) found in this application packet.									
Is anyone in yo	our household b	olind, disab	oled or incapacitat	ed? 🗌 Yes	☐ No				
Check the lang	uage in which	you want y	our notices printe	d. 🗌 Englis	sh 🗌 S	Spani	sh		
What language	is spoken in y	our home	?						
Case Number						D	ate Received		
The following s Name of perso				ation for the	person tha	at is a	pplying for assistan	ce. er (including area code)	
realife of perso	ii appiyiiig (i iic	ot, Last, IVI	'')				Telephone Number	(including area code)	
Address (stree	t. citv. state. zir	code)			Mailing a	addre	 ess only if different fr	rom vour residence.	
`		,			· ·		·	,	
List the names	of your children	n who are	under 18 years of	age, who do	not attend	d sch	ool full time.		
SECTION II					الملمطمون		mlar varimaalf amaria	- father weather shildren	
			on of all people livi oplication packet f					e, father, mother, children	
Providing or ap	plying for a So	cial Secur	ity Number (SSN)	is voluntary;	however a	any pe	erson who wants W	isconsin Medicaid, BadgerCare or	
Family Plannin	g Waiver, but d							nefits, pursuant to Wisconsin	
Statutes section	n 49.82(2).								
Name (Last, Fi	rst, MI)			Applying for			pplying for Family Planning Waiver	Social Security Number Applicant Only	
				or BadgerCare				Арріїсані Опіў	
Date of birth	Gender	Marital	U.S citizen	☐ Yes Race or eth	□ No	latio	Yes No	*Has paternity been established?	
(MM/DD/YY)		status	Applicant Only	code (optior		iatioi	nship to applicant		
	□M □F	Code	☐ Yes ☐ No				☐ Yes ☐ No		
	Į.								
Name (Last, Fi	rst, MI)			Applying for or Badge			pplying for Family Planning Waiver	Social Security Number Applicant Only	
				_			ŭ	PF 7	
Date of birth	Gender	Marital	U.S citizen	☐ Yes Race or eth	□ No nic Re	elation	☐ Yes ☐ No nship to applicant	*Has paternity been established?	
(MM/DD/YY)	□ M □ F	status Code	Applicant Only ☐ Yes ☐ No	code (optior	nal)			☐ Yes ☐ No	
		Code							
Name (Last, Fi	rst MI)			Applying for	Medicaid	ΙΑ	pplying for Family	Social Security Number	
ramo (Last, i not, mi)				or Badge			Planning Waiver	Applicant Only	
				☐ Yes	□No		☐ Yes ☐ No		
Date of birth	Gender	Marital	U.S citizen	Race or eth	nic Re	elation	nship to applicant	*Has paternity been established?	
(MM/DD/YY)	□M □F	status Code	Applicant Only ☐ Yes ☐ No	code (optior	iai)			☐ Yes ☐ No	
				1					

^{*}Complete only if the parents of this child were not married at the time of the child's birth. Check "Yes" if paternity has been established by a court action, or "No" if it has not.

WISCONSIN FAMILY MEDICAID / BADGERCARE APPLICATION

HCF 10100 (Rev. 04/04)

Name (Last, First, MI)			Applying for M or Badger(Applying for Family Planning Waiver	Social Security Number Applicant Only					
				☐ Yes ☐	No	☐ Yes ☐ No					
Date of birth	Gender	Marital	U.S citizen	Race or ethnic		lationship to applicant	*Has paternity been established?				
(MM/DD/YY)	□M □F	status Code	Applicant Only ☐ Yes ☐ No	code (optional)		☐ Yes ☐ No				
SECTION IV – ABSENT PARENT INFORMATION If there is a reason that you do not want to provide information for an absent parent leave this section blank. You will be contacted by your local county/tribal social or human service agency for additional information. If you are a woman between the ages of 15 and 18 and applying only for the Family Planning Waiver for yourself, leave this section blank											
Do any childre	Do any children (including unborn children) have a natural or adoptive mother or father who is not living at home? Yes No										
What is the na	me of the abse	nt parent?	(Last, First, MI)		What is toorn.)	the child's name? (Write	in "Unborn" if the child has not been				
SECTION V	– EMPLOY	MENT									
Are you or any	household me	mber worl	king? 🗌 Yes 🔲	No	Is anyo	ne listed below a migran	t worker? Yes No				
			er in your househol	ld (including you							
Name of worki	ng person (Las	t, First, Mi)		Empl	loyer's name, address ar	nd telephone number				
Date employm	ent began (MM	/DD/YY)									
	earnings this nand deductions										
	earnings next and deductions)										
Name of worki	ng person (Las	t, First, M)		Empl	loyer's name, address ar	nd telephone number				
Date employm	ent began(MM/	DD/YY)									
	earnings this nand deductions										
	earnings next and deductions										
SECTION V	'I - SELF-EN	//PLOYI	MENT								
Are you or any	household me	mber self-	employed?	s 🗌 No							
If you answered "Yes", complete the rest of this section. List the amounts you reported to the IRS on your tax form. If you did not file taxes last year, leave the net annual income and depreciation boxes empty. If you leave these blank, your local county/tribal social or human services agency will contact you for more information.											
Name of self-e	mployed perso	n (Last, F	irst, MI)		N	ame and address of bus	iness				
Net annual inc	ome \$										
Depreciation a	mount claimed	\$									
	it of net annual		efore taxes and do	eductions) that y	you T	ype of business					

WISCONSIN FAMILY MEDICAID / BADGERCARE APPLICATION HCF 10100 (Rev. 04/04)

Name of self-employed person (Last, First, MI)				Name and address of business			
Net annual income \$							
Depreciation amount claimed \$							
List the amount of net annual income (before tax expect to earn this year \$	xes and deduc	ctions) that	t you	Type of business			
SECTION VII – UNEARNED INCOME Types of unearned income includes Social Secu Unemployment Compensation, Disability / Sick					Support, Worker's /		
Does anyone in your household receive unearne	ed income?] Yes [] No				
If you answered "Yes", complete the rest of this	section for ea	ch person	who r	eceives unearned income.			
Type of income	Name (Last, F	First, MI)			Gross monthly amount		
SECTION VIII – INSURANCE							
In the current month or in the last 18 months, ha coverage under an employer-provided major me							
☐ Yes ☐ No If "Yes", which family memb	•	•	•	•			
Family Members Name:	ier(s) could ria	ve been in	isuicu	under uns neatur plan:			
Tarmy Wembers Name.							
Does any person have medical / health insurance	ce coverage no	ow, or in th	ne pre	vious three months? Yes] No		
If you answered "Yes", complete the rest of this	section						
Name and address of insurance company		Policyho	older's	name			
		Policy no	umber				
		Date beg	gan	Date e	nded		
		Who is covered under this policy?					
SECTION IX – CHILD CARE		1					
Does anyone pay for child or adult care so they	can work, lool	k for work,	go to	school or receive training?	es 🗌 No		
If you answered "Yes", complete the rest of this	section for the	e person w	ho pa	ys for the care.			
Name of person who pays for the care				whom is this care provided?			
Name of person providing the care				Does this person live in your household?			
SECTION X – CHILD SUPPORT							
Does anyone pay child support? Yes N	lo						
If you answered "Yes", complete the rest of this section for the person in your household who pays child support.							
Who pays child support?	Who	o receives	the ch	nild support payments?	Monthly amount		
					\$		

WISCONSIN FAMILY MEDICAID / BADGERCARE APPLICATION HCF 10100 (Rev. 04/04)

SECTION XI – PREGNANC	CY									
Is any member of your household pregnant? Yes No										
If you answered "Yes", complete the rest of this section for the pregnant women in your household. You will need to provide verification from a medical professional of the pregnancy and the due date to your local county/tribal social or human service agency.										
Name of pregnant woman Due date Are multiple births expected? Number of babies expected?										
		☐ Yes	□ No							
Your signature on the application the state Department of Health an	SECTION XII – RIGHTS AND RESPONSIBILITIES Your signature on the application means that you understand and acknowledge that the county/tribal social or human services agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid, BadgerCare and Family Planning Waiver programs authorized under Wisconsin law.									
	action taken concerning your Medicaid n by requesting a Fair Hearing. You m									
	Wisconsin Department of Administration Division of Hearings and Appeals P.O. Box 7875 Madison, WI 53707-7875									
Or by calling:	Telephone (608) 266-7709									
The "Request for Fair Hearing" for	m can also be found on the Division o	f Hearings and Ap	peals web site at	http://dha.state.wi.us/home/.						
	e I applied and ask for assistance with igibility and Benefits brochure (PHC 10									
The Department of Health and Far (608) 266-3465 (voice) or (608) 26	mily Services (DHFS) is an equal oppo 66-2555 (TTY).	ortunity employer a	and service provid	der. For civil rights questions, call						
To file a complaint of discrimination	n contact either the:									
Affirmative Action and Ci 1 W. Wilson, Room 555	Wisconsin Department of Health and Family Services (DHFS) Affirmative Action and Civil Rights Compliance Office 1 W. Wilson, Room 555 Madison, WI 53707-7850									
Telephone: (608) 266-93 Fax: (608) 267-2147	372 (Voice); (608) 266-5555 (TTY)									
OR										
U.S. Department of Health and Human Services Office for Civil Rights – Region V 233 N. Michigan Avenue, Suite 240 Chicago, IL 60601										
Telephone: (312) 886-5	Telephone: (312) 886-5077 (voice) or (312) 353-5693 (TTY)									
for giving false information or brea the best of my knowledge, includir understand and agree to provide o organizations to obtain the necess	sibilities and I understand the questions liking the rules. I certify, under penalty and information provided about the citized documents to prove what I have said.	of false swearing, enship status of ea I understand that t	that all my answ ich household me he agency may o	ers are correct and complete to ember applying for benefits. I						
SIGNATURE – Applicant or Authorized Representative Date signed										

Division of Health Care Eligibility HCF 10100B (04/04)

REQUEST FOR MEDICAID BACKDATED COVERAGE

If you are found eligible for Medicaid, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in those months. If you want help paying for health care for any of the three months prior to your application date (backdated coverage), make sure you checked the "Yes" box on the application where this question is asked and complete this form.

If there are any differences in circumstances in any of the three months prior to your application month list the differences below for each month that you are requesting backdated coverage. Differences may include: address, household composition, income, assets (only if someone in your household is 65 years of age or older, blind or disabled), vehicles, insurance.

Month 1 will be the earliest month that you could be found eligible. Example, if you applied June. June is your application month. You have medical bills in March and want backdated coverage to March. March is month 1, April is month 2 and May is month 3. Complete the following questions for each month that you have medical bills and want backdated coverage.

and want backdated coverage.			
Month 1			
Are you requesting backdated coverage for this month? Yes No Is any information included in your application different in this month from describe the changes.		□No	If "Yes",
Month 2			
Are you requesting backdated coverage for this month? Yes Notes that your application different in this month from describe the changes.		□ No	If "Yes",
Month 3			
Are you requesting backdated coverage for this month? Yes Notes that your application different in this month from describe the changes.		□No	If "Yes",
SIGNATURE - Applicant	Date Signed		

DEPARTMENT OF HEALTH AND FAMILY SERVICES

Division of Health Care Financing HCF 10137 (Rev. 04/04)

STATE OF WISCONSIN

Administrative Rule HFS 102.01(6)

MEDICAID CHANGE REPORT

If you are receiving Medicaid you must report any changes in your household composition (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), address, income, assets (only people age 65 or older, blind or disabled) or employment status **within ten days**. If such a change has occurred, fill out this report and mail it or take it to the office shown in the box below, or contact your worker by telephone or in person about any changes. If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report

report.						
	County agen	icy address)				
Your Name		Case Number		Work	ker Name	
If you intentionally fail to report any openefits you wrongfully received, be						
SECTION I - CHANGE IN ADDR						
Date of change	ew address.		New telephone num	ber		
New address (street, city, state, zip	code)					
SECTION II - CHANGE IN HOUS You must report if anyone moves in	or out of yo	ur household, if a	nyone gets married, b	ecome	es pregnant, or gives birth to a	
baby (include information about the Name(s) (Last, First, MI)	person who	gave birth and th	e newborn.)		Date of change	
Social Security Number (SSN)*	Date of bir	th		Relationship to Head of Household		
Describe the change						
*Providing or applying for an SSN is provide their SSN or apply for one w SECTION III - CHANGE IN INCO	vill not be eli					
You must report a change in your gr time to full-time or full-time to part-tin Security, Veterans benefits, Unemply your household receives.	ross income me, loss of e	employment), cha	nges in salary or rate	of pay,	, changes in the amount of Social	
Name (Last, First, MI)				I	Date income changed	
Source of income		Monthly amount		I	How often Paid	

SIGNATURE - Participant

SECTION IV - CHANGE IN ASSETS											
Those who are elderly, bl assets.			rt change	s in their cash, bank ac	counts, t	oonds, stoo	cks, vehicles or other				
Name of owner (Last, First, MI) Date of change											
Type of asset		New value or amount \$									
Name of owner (Last, First, MI) Date of change											
Type of asset	New value or amount \$										
SECTION V - CHANG											
Report if you obtain, sell of Name of owner (last, first		a car, truck,	motorcyc	le, boat, snowmobile, c	amper, o	Date of ch	, ·				
Type of vehicle	Make	Model	Year	Amount received	Docorik	oo chango	(bought, sold, etc.)				
Type of verticle	Wake	Model	Teal	\$	Descrit	be change	(bought, sold, etc.)				
SECTION VI - OTHER											
Report any other changes getting or dropping health other change.											
Describe change											
Do you expect that the changes reported on this form will remain the same next month? Yes No											
If No, explain.											
SECTION VII – SIGNATURE											
I understand that there are back any benefits I receive changes, if asked to do s	e because I	do not fully re	eport cha	nges in my circumstand	ces. I agr	ree to provi	ide proof of any				
changes, if asked to do so. My answers on this form are correct and complete to the best of my knowledge. SIGNATURE – Participant Date signed Telephone number											